Second Quarter 2002 Summary of Incidents, Complaints, Enforcement Actions

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"Any complaints and or incidents involving hospitals on or after August 30, 1999 are not releasable under the Texas Public Information Act & The Health and Safety Code Chapter 241.051 (d). The text of these summaries will not appear in this report"

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SUMMARY OF INCIDENTS FOR SECOND QUARTER 2002

I-7883 - Radioactive Material Found - Chaparral Steel Midlothian LP - Midlothian, Texas

On April 11, 2002, the Licensee notified the Agency that a device containing radioactive material had been detected in a load of scrap metal received from a scrap metal processor. The Licensee contracted a source disposal firm to determine the isotope and activity of the material and identify the device. Evaluation indicated the material was radium-226 with an activity of less than 1 millicurie. The material was transported to the disposal firm where the device was determined to be a commercial smoke detector containing one, 25 microcurie Ra-226 source, and two, ¼-inch long wires of americium-241, with an activity of 2 microcuries each. The sources were stored pending shipment to a permanent waste repository. No violations were cited.

File Closed.

I-7884 - Equipment Malfunction - Exxon Mobil - Baytown, Texas

On April 8, 2002, the Licensee notified the Agency that a Generally Licensed device, containing a 10 millicurie cadmium-109 source, had a shutter stuck in the open position. The equipment operator became aware of the problem immediately and notified the radiation safety officer. The device was removed from service and sent to the manufacturer for repairs. No excessive exposures occurred as a result of the incident.

File Closed.

I-7885 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7886 - Leaking Source - SPECTRO - Marble Falls, Texas

On April 16, 2002, the Licensee notified the Agency of a leaking 100 millicurie Fe-55 source. The leaking source was located in an instrument being returned to the manufacturer for disposal. The source was removed and placed in storage pending disposal. Wipe tests detected no contamination on the instrument. It was disposed of immediately. No violations were cited.

File Closed.

I-7887 - Therapy Event - Don and Sybil Harrington Cancer Center - Amarillo, Texas

On April 16, 2002, the Registrant notified the Agency of a therapy event that occurred on March 19, 2002, when the wrong patient was treated with an accelerator. The wrong patient responded

positively to a technologist and was escorted to the treatment room. The treatment accelerator was prepared for treatment of the intended patient. During this time a shift change also occurred at the facility. Port films were taken and treatment was initiated for the wrong patient. This was discovered when the next patient was called and only one patient remained in the waiting room. The technologist informed the other technologists that the wrong patient was on the treatment table. Treatment was immediately terminated and the dosimetry and physics staffs were notified. The prescribing physician, physicist, and technical director compared the treatment plans, simulation, and port films of both patients and determined that both plans and ports were nearly identical, with slight dose differences only in the monitoring units. The patient given the wrong treatment had the treatment corrected during the next treatment session. The prescribing physician determined that the patient will have no adverse affects from the event. The patient and prescribing physician were notified of the error. The staff was in-serviced on patient identification. To prevent a recurrence, the facility is attempting to develop a patient identification card that will be used to open the patient's electronic treatment record. No violations were cited.

File Closed.

I-7888 - Equipment Malfunction - Conam Inspections, Inc. - Pasadena, Texas

On April 23, 2002, the Licensee notified the Agency that failure to perform a radiation survey resulted in a radiation exposure to a radiographer trainer and a radiography trainee. During radiography operations at a field site the source was supposedly retracted to the fully-shielded position. A radiation survey was allegedly conducted by the trainee under the supervision of the trainer. However, when they attempted to reposition the exposure device the trainee's audible alarm sounded. At that time the survey meter was observed to be off-scale. The source was then retracted to the fully shielded and locked position. Both individuals then noted their pocket dosimeters were offscale. The trainer and trainee film badges were sent for emergency processing. The trainer received a 771 millirem exposure and the trainee received a 629 millirem exposure. Inspection of the locking mechanism of the exposure device revealed dirt and debris. The locking mechanism was cleaned and lubricated and functioned without problem. The trainer and trainee were issued company reprimands for failure to follow company procedures. To prevent future occurrences, the entire radiography staff were informed of the incident, the suspected causes, and the steps necessary to prevent a recurrence. The subject will again be reviewed during annual refresher training. The Licensee and radiographer trainer were cited for failure to survey to ensure the source was fully retracted prior to attempting to move the exposure device.

File Closed.

I-7889 -* Health and Safety Code-Chapter 241.051(d)

I-7890 -* Health and Safety Code-Chapter 241.051(d)

I-7891 - Unauthorized Disposal - Mallinckrodt Incorporated - Dallas, Texas

On April 30, 2002, the Mesquite Fire Department notified the Agency that 13 briefcase type devices were found at several residential trash pickup sites. Eleven of these cases were labeled "Radioactive Material." The Mesquite Police Department Bomb Squad performed explosive entry on two of the cases, as potential bomb threats. An Agency investigation determined the cases were old style unit dose transport cases that belonged to a nuclear pharmacy Licensee and apparently had been taken or stolen from the Licensee approximately 9 years earlier. The cases contained no radioactive materials and were returned to the Licensee for disposal. The Licensee has instituted procedures to number each transport case to identify the facility where each case is used. No violations were cited.

File Closed.

I-7892 - Overexposure - Goolsby Testing Laboratories, Inc.- Humble, Texas

On April 26, 2002, during a routine inspection of the Licensee's facility, an Agency inspector noted a 6,048 millirem exposure to an industrial radiographer during the 2001 monitoring period. The Licensee failed to notify the radiographer that he had exceed his annual exposure limit and failed to submit a 24-hour notification and a 30-day written report to this Agency. The Licensee was cited for the violations.

File Closed.

I-7893 - Lost Source - Texas Department of Health, Bureau of Radiation Control, Radiological Emergency Preparedness (REP), - Austin, Texas

On April 11, 2002, an Agency employee notified the Agency that a 0.03 millicurie exempt cobalt-60 source was lost during a radiological training exercise. The source had been placed in a bird nest for an exercise on locating radioactive sources. The source was discovered missing during the exercise. It is suspected the bird disposed of the foreign object in the nest. In order to prevent a recurrence of this incident, trainers have been instructed not to place sources near known animal nests or lairs.

File Closed.

I-7894 - Stolen X-ray Equipment - Southwest Medical and Dental - Dallas, Texas

On May 14, 2002, the Registrant notified the Agency that an x-ray unit was stolen on that day. A dental office was broken into and in addition to the x-ray machine, a film processor, dental stools, four clean water systems, an ultrasonic cleaner, a drill and charger, a dental light, and a tool box were stolen. The Registrant reported the incident to the Carrollton Police Department. The unit has not been recovered. To prevent a recurrence all of the locks were changed and a burglar alarm system was installed.

File Inactive.

I-7895 - Badge Overexposure - Gulf Coast Weld Spec - Orange, Texas

On May 6, 2002, the Licensee notified the Agency of a 71,976 millirem exposure to a radiographer trainer during the April 1 to April 30, 2002, monitoring period. On April 17, 2002, a radiographer trainee carried a bucket of tools into the restricted radiation area and began radiography operations under a trainer's observation. The trainer remained outside the restricted radiation area and looked for his film badge. After the exposures were complete, the trainee found the trainers film badge in the bucket of tools. The radiation safety officer was notified and the badge was sent for immediate processing. The Agency granted a deletion of the 71,976 millirem exposure and accepted a 168 millirem assessment, based on the average exposure to the trainer during the previous nine months, to be added to the trainer's exposure history.

File Closed.

I-7896 - Stolen Moisture Density Gauge - HVM Associates, Inc. - Austin, Texas

On May 20, 2002, the Licensee notified the Agency a moisture density gauge, containing a 10 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was stolen that day from a truck parked behind the Licensee's office. The gauge was found by a security guard later during the day, on a curb behind a shopping plaza. The guard notified the Austin Fire Department and the department's Hazardous Materials team isolated the gauge and called the Agency. The Agency notified the Licensee and responded to the location. The Licensee determined the gauge was not damaged and the sources were not leaking. No excessive exposures were received during the incident. The Licensee took possession of the gauge. No violations of Agency regulations were noted.

File Closed.

I-7897 - Leaking Source - Thermo Measure Tech - Round Rock, Texas

On May 13, 2002, the Licensee notified the Agency that during preparation for source disposal, an eight curie cesium-137 source was found leaking. The source was placed in a lead shield pending disposal. The area and one pair of worker's shoes were decontaminated. Another pair of shoes and a small wooden pallet were bagged and placed in a waste drum. No violations were noted.

File Closed.

I-7898 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7899 - Unauthorized Use of Radioactive Material - Texas A&M University Environmental Health and Safety Department - College Station, Texas

On May 23, 2002, the Licensee notified the Agency that a 9.8 millicurie cesium-137 source was stored in an unauthorized manner aboard a Licensee research vessel from March 2000 to April 2002. The research vessel, with the source still on board, was sold to an unlicensed company. The source was discovered missing when a leak test became due during December, 2001. The leak test was performed during April 2002, when the source was returned to the Licensee. The Licensee was cited for violations of Agency regulations and for violation of the Licensee's Policy Manual.

File Closed.

I-7900 - Therapy Event - Don and Sybill Harrington Cancer Center - Amarillo, Texas

On May 29, 2002, the Licensee notified the Agency of a therapy event that occurred that day. During therapy, the patient was not properly positioned and treatment intended for the inferior edge of the field was misplaced and delivered to the superior portion of the field. The incorrect positioning of the treatment location resulted in the misadministration of 90-cGy to the right aspect of the patient's brain, rather than the right side of the neck and head. Review of the positioning error showed the patient's eyes were not involved and the deviation consisted of 1.4% of the total dose. The patient and referring physician were notified of the error. To prevent a recurrence, the Licensee conducted in-services with the therapy personnel, assigned additional staff to the treatment unit, defined tighter parameters to verify and document correct positioning, and implemented placement of misadministration documentation in the individual therapist's file.

File Closed.

I-7901 - Stolen Density Gauge - Hunter Industries, LTD. - San Marcos, Texas

On May 29, 2002, the Licensee notified the Agency that a density gauge, containing a seven curie cesium-137 source, was stolen between the hours of 2 p.m. on May 16, 2002, and 7:30 a.m. on May 20, 2002. The gauge was stolen from the rear of a company pickup by prying open the transport container and removing only the gauge. The stolen gauge had not been properly checked out from the authorized storage facility and it had been taken home for the weekend by the operator after completing a job, rather than returning it to the authorized storage area. Several additional violations of the Licensee's operating, safety, and emergency procedures were noted. The Licensee was cited for these violations and the radiation safety officer was cited for failure to complete required duties outlined in Agency regulations. The gauge has not been recovered.

File Inactive.

I-7902 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7903 - Source Abandoned Downhole - Schlumberger Technology Corporation - Edinburg, Texas

On April 22, 2002, the Licensee notified the Agency that a 1.7 curie cesium-137 source was abandoned downhole after multiple unsuccessful recovery attempts. The source was abandoned at a depth of 16,287 feet and immobilized by red dyed cement to a depth of 14,800 feet, with a whipstock installed to a depth of 14,690 feet.. The source was abandoned in accordance with Railroad Commission of Texas Rule 35 and Texas Regulations for Control of Radiation, 25 TAC §289.253.

File Closed.

I-7904 - Leaking Source - SPECTRO - Marble Falls, Texas

On May 19, 2002, the Licensee notified the Agency that a 100 millicurie iron-55 source, located inside a proportional counter, was leaking. A routine leak test revealed 42.33 microcuries of removable activity. The contamination was confined to the face of the source, the proportional counter window and filter tray. The source was removed from service and placed in storage pending disposal. The window and tray were decontaminated. All other interior and exterior surfaces of the instrument were wipe tested and determined to have no detectable contamination.

File Closed.

I-7905 - Radioactive Material Found - Chaparral Steel Midlothian, LP / Thermo MeasureTech - Midlothian / Round Rock, Texas

On June 4, 2002, the Licensee notified the Agency that a small radioactive device had been detected in a load of shredded scrap. The Licensee also notified Thermo MeasureTech of the discovery and requested assistance in identification and disposal of the device. The device was collected from the site and transported to the Licensee's laboratory for identification. The device was identified as an industrial smoke detector that consisted of two 0.002 millicurie americium-241 sources, and a 0.025 millicurie radium-226 source. The sources were accepted by Thermo MeasureTech for disposal.

File Closed.

I-7906 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7907 - Stolen Moisture Density Gauge - Fugro South, Inc. Houston, Texas

On June 12, 2002, the Licensee notified the Agency that a moisture density gauge, containing an 8 millicurie cesium-137 source and a 40 millicurie americium-241/beryllium source, was stolen from a company pickup truck parked at a fast food restaurant. The security chain was cut and the gauge, in it's transport case, was removed from the truck. A police report was filed with the Houston Police Department. To prevent a recurrence, the Licensee has upgraded all chain and lock systems currently used on vehicles transporting moisture density gauges. A company memo was issued to all operators, reiterating company security policies and increased vigilance levels to be observed by all employees. The gauge has not been recovered.

File Inactive.

I-7908 - Dose Irregularity - UT Southwestern Cancer Center / Mallinckradt - Dallas, Texas

On June 21, 2002, the Licensee notified the Agency that a dispensing error and misadministration had occurred that day. The nuclear pharmacy dispensed the wrong bulk dose of a radiopharmaceutical to a hospital for bone imaging studies. The hospital administered the dose because the labeling indicated the dose was as ordered. However, upon imaging the error was discovered and further administrations were suspended immediately. As a result of the error, four patients were administered incorrect doses. The whole body doses were less than 5 rem, and no organ received greater than 50 rad. The dispensing error occurred as a result of personnel not following standard procedures for dispensing radiopharmaceuticals. To prevent a recurrence of the dispensing error, the nuclear pharmacy converted from bulk product to unit doses. Also, proper dispensing procedures were reviewed along with the use of daily prescription sheets to verify doses. The incident was referred to the Board of Pharmacy for possible actions under their regulations.

File Closed.

I-7909 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7910 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

I-7911 - Radioactive Material Contamination - Biotech Pharmacy, Inc. - El Paso, Texas

On June 11, 2002, the Licensee notified the Agency of the receipt of a package with elevated surface readings on June 6, 2002. The package contained the Licensee's standing order of 10 vials, of 10 millicuries each, of Xenon-133 gas. Upon opening the package, it was discovered one of the vials had leaked and contaminated the packaging. The box, packaging, and vial that leaked were place in a fume hood for decay. When the manufacturer was notified the vial had leaked, they requested the return of the vial to determine the cause of the leakage. The vial was returned to the manufacturer on June 10, 2002. No violations were cited.

File Closed.

I-7912 - Radioactive Material Lost - University of Texas - Austin Texas

On June 28, 2002, the Licensee notified the Agency that a 1.36 microcurie lead-210 source could not be located. The faculty member who used the source was no longer at the university. A visual inspection and radiation survey of the use laboratory, the surrounding rooms, and hallways did not locate the source. The Licensee believes the source either remains at the university or was discarded in the normal trash. To prevent a recurrence, the radiation safety officer will send a memo to authorized users on responsibilities related to closeout surveys and procedures for transferring radioactive material; emphasis will be placed on proper procedures during basic and refresher radiation training; and a source accountability system will be developed and implemented for authorized users. The Licensee was cited for the violation.

File inactive.

I-7913 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

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COMPLAINT SUMMARY FOR SECOND QUARTER 2002

C-1666 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1667 - Unregistered Laser - Skin Care Studio / Technology Delivery Systems, Inc. - Grapevine, Texas / Baton Rouge, Louisiana

On March 28, 2002, the Agency received a complaint alleging an unregistered, out-of-state company, was providing laser equipment to an unregistered salon. Also of concern was the issue of physician supervision during the laser procedures. An Agency investigation determined the facility was closed and had ceased using laser equipment. During laser usage at the studio, a technologist from the laser firm registered with the Agency as a provider of equipment, operated the equipment. There was no medical director or licensed practitioner at the studio. The provider of equipment had a Texas licensed practitioner, who was not onsite during laser procedures and provided prescriptions for laser use without establishing a doctor-patient relationship. In addition, the facility was still in possession of an IPL device that is not approved by the U.S. Food and Drug Administration. The name of the distributor of the unapproved device was provided by the user. Information on the unapproved device and the distributor were forwarded to the Texas Department of Health's Bureau of Food and Drug Safety, Medical Devices. The name of the Medical Director, a Texas licensed practitioner of the healing arts, was forwarded to the Texas Board of Medical Examiners for possible actions under their rules.

File Closed.

C-1668 - Uncredentialed Technologist - Accent Podiatry Association - Arlington/Mansfield, Texas

On March 17, 2002, the Agency received a complaint alleging a Registrant allowed an uncredentialed technologist to perform radiographs. An Agency investigation substantiated the allegation. The Registrant was cited for the violation. Violations were also cited for failure to monitor the occupational exposure to an occupationally exposed individual and failure to maintain personnel monitoring records at the authorized use location.

File Closed.

C-1669 - Regulation Violations - Matrix Metals, LLC dba Richmond Foundry - Richmond, Texas

On April 30, 2002, the Agency received an anonymous complaint alleging the Licensee: failed to

perform required surveys in a timely manner; used radiation sources without direct surveillance; used radiation sources without the required number of personnel present, as required by standard operating procedure; failed to perform leak testing of radiation sources within the required frequency; allowed non- occupationally exposed personnel to work in an area where radiation levels exceeded 100 millirem per year; utilized alarming dosimeters that were out of calibration; failed to have emergency phone numbers available for employees; falsified training hours for required personnel; and an unclear allegation of "P and M's not being performed", that was not clarified by the anonymous complainant. An Agency investigation conducted on May 1, 2002, could not substantiate any of the allegations. No violations were cited.

File Closed.

C-1670 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1671 - Unregistered Laser Users - Harmonix /Coppell Wellness Center - Plano, Irving, and Coppell, Texas

On April 23, 2002, the Agency received a complaint alleging ten facilities were operating lasers and/or Intense Pulsed Light (IPL) devices without a registration and without a physician on site during procedures with these instruments. Joint inspections performed by the Bureau of Radiation Control and TDH Food and Drug, Medical Devices determined eight of the ten facilities had only IPL devices, currently not regulated by this Agency. Two Harmonix facilities had used Class IV lasers for more than 30 days without registering with the Agency. The Coppell Wellness Center operated two Class IV lasers for more than 30 days without registering with the Agency. The three facilities were cited for failure to register the lasers within 30 days of beginning use of the lasers. Three of the other facilities were referred to the Texas State Board of Medical Examiners for failing to have a licensed practitioner on site during use of either lasers or IPL devices.

File Closed.

C-1672 - Unregistered X-Ray Equipment - Desert Imaging Services - El Paso, Texas

On May 7, 2002, the Agency received an anonymous complaint alleging an unregistered mobile x-ray company allowed an uncredentialed technologist to perform radiographs. An Agency investigation determined the company was registered with the Agency and the technologist was credentialed. The Registrant failed to maintain a copy of the regulations on the mobile van. The Registrant was cited for the violation.

File Closed.

C-1673 - Internal Contamination - Tony Gomez - Huntsville, Texas

On May 14, 2002, the Texas Natural Resource Conservation Commission forwarded to the Agency a complaint alleging an inmate incarcerated by the Texas Department of Criminal Justice believed he had been internally contaminated by unknown sources of radiation. The complaint alleged the exposure to radioactive and hazardous wastes occurred during employment periods in the years 1967, 1970, 1973, 1974, and 1983. An Agency attempt to obtain access to the inmates medical records for review of symptoms of radiation exposure was denied by the inmate. The investigation was closed.

File Closed.

C-1674 - NORM found - Smith Ranch - Port Lavaca, Texas

On May 17, 2002, the Agency received a complaint alleging a scrap metal yard rejected oil field pipe because of radiation levels. An Agency investigation determined the pipe contained naturally occurring radioactive material (NORM). The highest radiation level detected was 100 microrem per hour on contact with one 10 foot-piece of pipe. An Agency survey of where the pipe had been stored did not detect any radiation levels above background. The health risks from the exposure to the pipe would be minimal. The pipe with radiation exposure levels that did not exceed the limit of 50 microrems per hour is exempted from Agency regulation. The piece of pipe with the radiation level of 100 microrems per hour exceeds the limit and is subject to regulations contained in 25 Texas Administrative Code §289.259. Transfer for disposal of this pipe must be to a person specifically licensed to receive waste containing NORM. Further, persons conducting deliberate operations to decontaminate this pipe must be specifically licensed with Agency. The individual in possession of the pipe was notified of the regulatory requirements.

File Closed.

C-1675 - Unauthorized X-Ray Screening - Midland Imaging Center dba Golder X-Ray - CAT Scan & MRI Center - Midland , Texas

On May 20, 2002, the Agency received a complaint alleging the registered facility was performing screening CT scans without authorization of a licensed practitioner. An Agency investigation is pending.

File Open.

C-1676 -* Health and Safety Code-Chapter 241.051(d)

File Closed.

C-1677 - Unregistered Bone Densitometer - Whole Health / Lane Lab - Tyler / San Antonio, Texas

On May 18, 2002, the Agency received an anonymous complaint alleging an unregistered bone densitometer would be in use at the Health Fair in Tyler. The equipment would be provided by Lane Lab. An Agency investigation determined that the instrumentation to be used at the Health Fair did not require registration with this Agency due to it's operation as an ultrasound device versus the perceived x-ray densitometer.

File Closed.

C-1678 - Regulation Violations - The Valentine Foundation, Inc. - Houston, Texas

On May 29, 2002, the Texas Department of Health's Bureau of Food and Drug Safety, Medical Devices Division transferred to this Agency a complaint alleging a Registrant moved a laser to an unauthorized location and would not disclose the location to the Agency. The Registrant contacted the Agency and alleged a physician was in possession of the laser and would not release it to the Registrant. An Agency investigation substantiated both allegations. The Registrant was cited for failure to notify the Agency of a change in authorized use and records location and was cited for failure to notify the Agency of a change that rendered the information on the Certificate of Laser Registration inaccurate.

File Closed.

C-1679 - Regulation Violations - Modern Back and Neck, Inc. - Dallas, Texas

On June 4, 2002, the Agency received a complaint alleging a female patient with lower back pain had excessive x-rays performed over her entire body. The complainant also alleged: she was never asked if she was pregnant; was not given any shielding during the x-ray procedures; the x-ray room was not posted as required by regulation; the x-ray equipment and processor were malfunctioning; and x-rays were not properly logged. An Agency inspection determined the x-rays were properly performed, the x-ray room was properly posted, including warnings to pregnant patients, and equipment was operating within acceptable limits as established by this Agency. The facility was cited for failure to monitor the occupational dose of the practitioner.

File Closed.

C-1680 - Regulation Violations - HCE & Technology - Houston, Texas

On May 29, 2002, the Agency received a complaint alleging a sales and service company ignores safety when servicing x-ray units, demonstrates on humans, and falsely performs service under another facility's registration. The Agency is investigating the complaint.

File Open.

C-1681 - Unregistered X-Ray Facility - One World Chiropractic - Austin, Texas

On May 31, 2002, the Agency received an anonymous complaint alleging an unregistered x-ray unit was in use at a chiropractic facility. It was further alleged the x-ray unit was exposing the public to radiation doses greater than allowed by Agency regulation. An Agency investigation determined the facility was registered with the Agency and was not in violation of dose limits to the public. The complaint was not substantiated.

File Closed.

C-1682 - Regulation Violations - Mandes Inspection & Testing Services - Houston, Texas

On June 7, 2002, the Agency received a complaint alleging radiographer trainees were allowed to perform radiography at job sites without a qualified trainer and the trainees were not wearing personnel monitoring devices. An Agency investigation determined a trainer was at the site, however, personnel monitoring devices were not worn. The Licensee and the radiographer trainer were cited for the following violations: all required records were not accurate and factual in that the daily radiation survey sheet was completed at the shop prior to arrival at the temporary job site; trainees were allowed to conduct industrial radiographic operations while not wearing personnel monitoring devices; areas of the temporary job site where radiography was performed were not posted; barriers and/or ropes were not used to designate restricted areas to prevent unauthorized entry; surveys were not performed during the first radiographic exposure to confirm unrestricted areas did not have radiation levels exceeding regulatory limits; packages of radioactive material were not secured to prevent shifting during transportation; visual and operational checks on radiography equipment was not performed to ensure good working order prior to use; the latest radiation survey records for the period of operation at the site were not available; and lock out surveys to determine the source was fully shielded before moving or securing the exposure device was not performed and documented. The Licensee was also cited for failure of the radiation safety officer to fulfill the required duties and responsibilities.

File Closed.

C-1683 - Regulation Violation - Iron Mountain Health Information Services - Houston, Texas

On June 21, 2002, the Agency received a complaint alleging a company refused to provide mammography films and reports to a former patient of a closed mammography facility. The mammography films and reports had been transferred to an information storage facility. It was alleged the storage facility had informed the patient the films and reports could only be transferred to another medical facility. Agency contact with the storage facility clarified Agency rules and explained requirements for release of mammograms and copies of patient reports. No violation was cited.

File Closed.

C-1684 - Regulation Violations - Third Floor Lab, Inc. - Dallas, Texas

On June 21, 2002, the Agency received a complaint alleging the Registrant did not provide lead aprons or use shielding for patients during radiographs and allowed an uncredentialed technologist to perform radiographs. An Agency investigation determined lead aprons were in use at the facility. Gonadal shielding was available but not used as required. Two technologists with noncertified technologist certificates performed procedures not allowed under the certification. The Registrant was cited for the violations.

File Closed.

C-1685 - Regulation Violation - Occupational Marketing, Inc. /N & M Inc. - Houston, Texas /Pascagoula, Mississippi

On June 24, 2002, the Agency received an anonymous complaint alleging a company was flagging people off a street for chest x-ray examinations by mobile x-ray units. An Agency investigation determined two law firms were interviewing passersby for potential exposure to asbestos and/or silica. If individuals met established criteria, they were directed to one of two mobile x-ray units for a chest x-ray. Only one mobile unit was observed by the inspector. However, the law firm supporting the one unit volunteered the name and contact information for the other unit that had been performing services at the location. Both mobile units were registered with the Agency and had authorization for mobile use.

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INCIDENTS CLOSED SINCE FIRST QUARTER 2002

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COMPLAINTS CLOSED SINCE FIRST QUARTER 2002

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APPENDIX A

SUMMARY OF HOSPITAL OVEREXPOSURES
REPORTED DURING THE SECOND QUARTER 2002

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APPENDIX B

SUMMARY OF RADIOGRAPHY OVEREXPOSURES
REPORTED DURING SECOND QUARTER 2002

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APPENDIX C

ENFORCEMENT ACTIONS FOR SECOND QUARTER 2002

Enforcement Conference: North Texas Neurology Association, L.L.P., Wichita Falls, TX – X-Ray Medical

On April 25, 2002, an Enforcement Conference was held with North Texas Neurology Associates, holder of Certificate of Registration No. R19134. The North Texas Neurology Associates representative attending the conference was Mr. Tommy L. Gream, R.T., R.S.O. Agency representatives attending the conference were Madames Alice Rogers (Chairman), and Cathy McGuire and Mr. Jack England.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on March 5, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jack England reviewed the violations and the responses to the violations. The Registrant's representative responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant will provide the Agency with a written statement detailing the film screen combination, film type and speed, developer ph replenishment rate, developer temperature, processor temperature and processor maintenance. This information shall be provided to the agency within 30 days from the date of this Enforcement Conference summary.

2. The Registrant's inspection frequency will be increased and unannounced inspections will be conducted.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. The Registrant's representative agreed to these items and the conference was concluded.

Enforcement Conference: Cyvon Imaging, Inc. Arlington, TX - Mammography

On May 16, 2002, an Enforcement Conference was held with Cyvon Imaging, Inc., holder of Certificate of Mammography No. M00702. Cyvon Imaging, Inc. representatives attending the conference were Mr. Bobby McHenry and Ms. Yvonne McHenry. Agency representatives attending the conference were Messrs. Thomas Cardwell (Chairman), Jerry Cogburn and Jack England, and Ms. Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on January 3, 2003. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jerry Cogburn reviewed the violations and the responses to the violations. The Registrant's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. Administrative penalties will be assessed on violation number 1 of the January 3, 2002 inspection and a preliminary report will be issued to the Registrant.

2. The Registrant will provide the Agency with a written response to the Notice of Violation issued on March 1, 2002, as well as the Notice of Violation issued on May 16, 2002. This information shall be provided to the agency within 10 days from the date of this Enforcement Conference summary.

3. The Registrant will remain at an increased inspection frequency and unannounced inspections will continue.

4. The Agency requests Dr. Sridhar S. Iyengar, R.S.O. and the lead interpreting physician will attend a radiation safety officer and mammography quality control class within 60 days from the date of this Enforcement Conference summary. Certificates of completion shall be provided to the Agency upon completion of the courses.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Dale Allen Hively - Hallsville, TX - Industrial Radiography

On May 30, 2002, an Enforcement Conference was held with Mr. Dale Hively, holder of Texas Radiographer I.D. No. 006721. Agency representatives attending the conference were Messrs. William Silva (Chairman), and Bob Green, and Madames Blinzia Foshko and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on September 25, 2002. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of his radiation safety practices.

Mr. Robert Green reviewed the violations and the responses to the violations. The Radiographer responded to the Notice of Violation. After reviewing the violations and responses, the Radiographer was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Radiographer will be issued a preliminary report with a total penalty amount of $300.00. The penalty is being assessed due to the Radiographer's failure to adequately secure, block and brace licensed radioactive material prior to transporting on a public highway. This failure resulted in a temporary loss of control of an industrial radiography sealed source and subsequent access of the exposure device by a member of the public. The penalty will be pro-rated over a 10 month period, and the first $30.00 per month payment will be due on July 15, 2002.

After the caucus, the Radiographer returned and was informed of the item discussed during the caucus. The Radiographer agreed to this item and the conference was concluded.

Enforcement Conference: Jimmy Joe Moon & Barbara Seid Moon, D.D.S., Inc., Pasadena, TX - X-Ray Dental

On June 14, 2002, an Enforcement Conference was held with Jimmy Joe Moon & Barbara Seid Moon, D.D.S., Inc., holder of Certificate of Registration No. R10925. Jimmy Joe Moon & Barbara Moon, D.D.S., Inc., representatives attending the conference were Dr. Jimmy Joe Moon, R.S.O. and Dr. Barbara Seid Moon. Agency representatives attending the conference were Mr. Jerry Cogburn (Chairman), and Madams Nancy Ivester and Cathy McGuire.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on December 11, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. Nancy Ivester reviewed the violations and the responses to the violations. The Registrant's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant will provide the Agency with a written statement indicating the radiation safety officer (R.S.O.) has read, understands, and will carry out the R.S.O. duties as indicated in 25 TAC §289.252(f). This statement shall be provided to the Agency within 30 days from the date of this Enforcement Conference summary.

2. The Registrant's inspection frequency will be increased and unannounced inspections will be conducted. No remote procedures will be performed by the Registrant until notification from the Agency has been received indicating the remote procedures will be resumed.

3. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II, or repeat violations are cited.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Palo Pinto General Hospital - Mineral Wells, TX - Mammography

On June 25, 2002, an Enforcement Conference was held with Palo Pinto General Hospital, holder of Certificate of Mammography No. M00471. Palo Pinto General Hospital representatives attending the conference were Dr. Roger Baker and Ms. Brenda Patton. Agency representatives attending the conference were Madames Alice Rogers (Chairman), Sarah Bernal and Cathy McGuire and Messrs. Jerry Cogburn and Jack England.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on March 12, 2002. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Jerry Cogburn reviewed the violations and the responses to the violations. The Registrant's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant will provide to the Agency proof that Dr. Taussig has read 240 mammograms, or have all mammograms previously read by Dr. Taussig re-read by a qualified physician. Verification will be submitted to the Agency within 30 days from the date of this Enforcement Conference summary.

2. The Registrant will include, on the Medical Outcome Audit Report, the dates of when the data was collected.

3. The Registrant's inspection frequency will be increased and unannounced inspections will be conducted.

4. The Registrant must use overall final assessment categories as defined in §289.230(c) for final assessment codes. A copy of medical reports demonstrating proper overall assessment of findings will be submitted to the Agency within 30 days from the date of this Enforcement Conference summary.

5. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II, or repeat violations are cited.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Alpha Treatment Centers, Inc. - Irving, TX - X-Ray Medical

On June 20, 2002, an Enforcement Conference was held with Alpha Treatment Centers, Inc., holder of Certificate of Registration No. R23338. Alpha Treatment Centers, Inc. representatives attending the conference were Dr. Mark L. Laning, R.S.O. and Mr. Andrew Hillman, Office Manager. Agency representatives attending the conference were Madames Alice Rogers (Chairman), Jackie Carter and Cathy McGuire and Mr. Thomas Cardwell.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on May 11, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Ms. Jackie Carter reviewed the violations and the responses to the violations. The Registrant's representatives responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representatives were excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant will provide the Agency with a written statement indicating the radiation safety officer (R.S.O.) has read, understands, and will carry out the R.S.O. duties as indicated in 25 TAC §289.252(f). This statement shall be provided to the Agency within 30 days from the date of this Enforcement Conference summary.

2. The Registrant will provide the Agency with a copy of the transfer and disposal form for the Continental X-Ray Unit within 30 days from the date of this Enforcement Conference summary. The Registrant will also provide the Agency with a copy of the receipt record for the new x-ray unit within 30 days from the date of this Enforcement Conference summary.

3. The Registrant will request, in writing, an amendment to its registration to add the new machine to their registration within 30 days from the date of this Enforcement Conference summary.

4. The Registrant will provide the Agency with a manual technique chart for the new machine within 30 days of the date of installation.

5. The Registrant will have a licensed medical physicist perform measurements on the new machine for the entrance exposures on the lumbar spine, cervical spine, and thoracic spine procedures and provide a copy of the physicist's report to the Agency within 30 days from the date of this Enforcement Conference summary.

6. The dark room safe light will be kept at 48 inches at all times. A new procedure shall be developed to alert the staff when the facility is out of film. This procedure shall be submitted to the Agency within 30 days from the date of this Enforcement Conference summary.

7. The Registrant will amend the current light leak test procedure to include a step whereby the film will be lightly exposed prior to commencement of the test to determine incidental light leaks. This procedure will be submitted to the Agency within 30 days from the date of this Enforcement Conference summary.

8. The Registrant will provide the Agency with legible copies of the equipment performance evaluation presented at the conference. This information will be provided to the Agency within 30 days from the date of this Enforcement Conference summary.

9. A copy of the apron inspection log will be provide to the Agency within 30 days from the date of this Enforcement Conference summary.

10. The Registrant's inspection frequency will be increased and unannounced inspections will be conducted.

11. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II, or repeat violations are cited.

After the caucus, the Registrant's representatives returned and were informed of the items discussed during the caucus. The Registrant's representatives agreed to these items and the conference was concluded.

Enforcement Conference: Gonzalez Chiropractic, El Paso, TX - X-Ray Medical

On April 16, 2002, an Enforcement Conference was held with Gonzalez Chiropractic, holder of Certificate of Registration No. R19134. The Gonzalez Chiropractic representative attending the conference was Dr. Carlos M. Gonzalez, D.C. Agency representatives attending the conference were Madames Alice Rogers (Chairman), and Cathy McGuire and Mr. Thomas Cardwell.

The purpose and the procedures for conducting the conference were explained. The conference was held as a result of a facility inspection conducted on October 20, 2001. This inspection determined the number and severity level and repetitiveness of the violations noted during this inspection have resulted in a significant, unacceptable deficiency with regard to the application and overall effectiveness of their radiation safety program.

Mr. Thomas Cardwell reviewed the violations and the responses to the violations. The Registrant's representative responded to the Notice of Violation. After reviewing the violations and responses, the Registrant's representative was excused while a caucus was held by the Agency representatives. During the caucus the following was determined:

1. The Registrant will provide the Agency with a written statement indicating the radiation safety officer (R.S.O.) has read, understands, and will carry out the R.S.O. duties as indicated in 25 TAC §289.252(f). This statement shall be provided to the Agency within 30 days from the date of this Enforcement Conference summary.

2. The Registrant's inspection frequency will be increased and unannounced inspections will be conducted.

3. New technique charts will be completed, posted to each machine, and a copy forwarded to the Agency within 30 days from the date of this Enforcement Conference summary.

4. The radiation technician will be trained on the new techniques and documentation will be provided to the Agency within 30 days from the date of this Enforcement Conference summary.

5. Dr. Carlos Gonzalez will complete a radiation safety officer training course. A copy of the certification of completion will be provided to the Agency within 90 days from the date of this Enforcement Conference summary.

6. The Registrant will provide the Agency with a copy of the December 2000 and December 2001 dosimeter reports, within 30 days from the date of this Enforcement Conference summary.

7. No administrative penalties will be assessed at this time, however, pending the outcome of future inspections, administrative penalties may be assessed if any Severity Level I, II or repeat violations are cited.

After the caucus, the Registrant's representative returned and was informed of the items discussed during the caucus. The Registrant's representative agreed to these items and the conference was concluded.

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